Chapter 10: New directions for suicide prevention in Approved Premises

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In this chapter, developments in suicide prevention and self-harm management within Approved Premises (AP) in England and Wales (E&W) will be outlined. Individuals who are in transition from prison to the community are at a high risk of suicide and serious self-harm, especially in the first few weeks' post-release. Therefore, although Probation staff have different roles and duty to prison or health professionals, it is important to ensure that there are structures and systems which can support suicide prevention and staff working with those who self-harm. This chapter will outline the rationale and content of approaches implemented to reflect the specific risks and needs of this population including a dual-stage case management approach: Support and Safety Plan (SaSP) and Collaborative Assessment of Risk and Emotion (CARE). These approaches aim to provide tailored support for all the men and women throughout their residency in an AP and provide both a preventative and responsive approach to suicidality and self-harm behaviour.

Prevalence of suicide within AP, prison leavers and those under probation supervision

Men and women on probation are at considerably higher risk of suicide than the general population with relative rates of suicide reported as being nine times that of the general population (Sattar 2003; Phillips, Padfield and Gelsthorpe 2018). Furthermore, people who leave prison exhibit a significantly higher rate of suicide, with a systematic review indicating this to be seven times the general population (Jones and Maynard 2013) especially with the very early post-release stage, with just over 20% of suicides within prison leavers occurring within 28 days of release. Official figures published by the Ministry of Justice (2020a) indicate that in England and Wales (E&W) for prison leavers who die (by any cause) within 12 months of release, 20% occur within the first 28 days of release, including up to 21 deaths (1-2 apparent suicides) per year occurring in AP, emphasising the need for the provision of additional support through this transitional phase (Ministry of Justice 2020a)

Approved Premises

Approved Premises (AP) are premises approved under Section 13 of the Offender Management Act 2007. APs are a public protection measure and provide intensive supervision and curfew in the community for those who are assessed as presenting with a high or very high risk of serious harm on release from prison; with some women included who are assessed as medium risk with additional complex needs (NOMS, 2014). APs provide a programme of purposeful activity to manage and reduce the risk of re-offending and practical support towards reintegration into society. Every person resident in an AP will have an allocated Keyworker to support them throughout their residency. In 2021, across England and Wales, there were 101 APs which provide accommodation to over 2000 people on post-release supervision i.e., prison leavers

who remain under probation supervision (HMPPS 2021). There are a small number who are directed by the courts to live in an AP as a condition of a court order. Further details on the current policies for APs including suicide and self-harm management and post-incident response are provided in PI 32/2014 Approved Premises and its Annex A: Approved Premises Manual (NOMS, 2014) with internal guidance and dynamic updates provided through national AP Instructions and an online system known as EQuiP (HMPPS, 2021).

APs were formerly known as probation hostels and although they provide prison leavers with accommodation, they are not part of the prison system. HMPPS therefore do not hold the same 'duty of care' to those in AP as those in custody and are not responsible for the assessment or treatment of clinical, substance or mental health needs in the community. This responsibility lies with the community health services provided through the Department of Health and Social Care (DHSC) and NHS England or NHS Wales, although HMPPS retain roles regarding wider wellbeing and health promotion and in facilitating and encouraging access to health services. The NPS Health and Social Care Strategy 2019-2022 outlines the Probation Service commitment to ensuring the safety of all individuals under supervision as far as reasonably possible. This includes raising awareness of suicide prevention and the heightened risk of suicide for those under supervision, working with multi-agency partners to support access to appropriate care and support services and a specific Approved Premises Reducing Self-Inflicted Death Action Plan (National Probation Service 2019).

National and International Guidance

It is widely acknowledged within national and international strategies that the transition into the community from prison is a high-risk time for suicide (Public Health England 2020; NICE 2018). Recently released prison leavers and those under probation supervision have significantly higher rates of complex needs including mental health problems, substance use and homelessness, which, in combination, may affect access or ability to engage with services (Public Health England 2020).

The distinct risks and needs of men and women in prison in relation to suicide or self-harm are well known with evidence-based guidance provided (Ministry of Justice 2020b; U.S. Department of Justice 2007). However, there is limited specific evidence or guidance provided for community or probation services on effective approaches to managing prison leavers' risk of suicide and self-harm (Sirdifield, Brooker and Marples 2020). In practice, the usual community assessment and services will be accessed or require prison leavers to access alternative pathways of care e.g. forensic services. As in prisons across England and Wales, the Prison and Probation Ombudsman (PPO) complete and publish fatal incident investigations within Approved Premises (Prison and Probation Ombudsman 2021) which allows for new learning to be identified and applied, a process which is in keeping with best practice guidance (NICE 2018)

Within prisons and correctional settings, international bodies have indicated similar key components for custodial-based approach to suicide prevention (World Health Organisation 2007; National Commission on Correctional Health Care 2019; NICE 2018). These included: Staff training; Intake screening which includes consideration of dynamic factors; Post-intake screening or ongoing observation; Management strategies once risk is identified; Consideration of social needs; Reducing access to the means of suicide or self-harm; an access, as required, to mental health services. There is some evidence of effectiveness of these elements in prisons (Slade and Forrester 2015) although this is limited.

Assessment and intervention

Although international guidance emphasises 'screening at intake' (World Health Organisation 2007), screening tools have been consistently found to be ineffective in supporting the prediction of suicide within those entering prison, with no evidence for tools in prison leavers (Gould, McGeorge and Slade 2018; Perry, et al. 2010). Consequently, NICE guidance does not recommend the use of any specific screening tool in custody or community (National Institute for Health and Care Excellence, (NICE) 2013). International studies have identified a small number of higher-risk groups for suicide in prison leavers in Australia and USA, reflecting risk groups in the general population e.g., being from an indigenous community, having previous serious self-harm, previously identified by prison staff as being at risk of self-harm, having previously been hospitalised for a psychiatric disorder and childhood trauma (Gunter, et al. 2011; Kariminia, et al. 2007). Very few distinct or modifiable risk factors have been identified in the men and women who die by suicide or engage in serious self-harm in the weeks or months post-release (Mackenzie, Cartwright and Borrill 2017). Although previous suicide attempt or self-harm is a notable risk factor, nearly half of all prison suicides do not have this history (Prison and Probation Ombudsman 2014), emphasising the need to ensure assessments reflect the individual.

A recent HMIP review on race equality highlighted a disproportionate experience and the need for probation staff to have a good understanding of the culture, religion, heritage or experiences of individuals under supervision (HM Inspectorate of Probation 2021). Furthermore, placement of assessment and systemic responses to suicide or self-harm risk within a person-centred and trauma-informed model of care has been recommended (Department of Health 2017). Person-centred care is based on the principles of personhood, individualised care and empowerment, considering the whole person within his/her social context, recognising their unique needs, experiences, values and preferences and supporting self-determination in decision-making and that care reflects any religious, ethnic, or cultural needs they have (Health Education England 2017). Trauma-informed approaches to care assist in creating physical, psychological, and emotional safety for individuals who may be suicidal. Research on systemic approaches have also emphasised the need for structured assessments and stated that care plans of prison leavers at risk of suicide by multi-disciplinary teams should be developed and monitored (Pratt, et al. 2006) with an

emphasis on the need for a clearer transition for prison leavers, including information flow (Phillips, Jake, et al. 2016).

Safety Planning

There is growing evidence that brief suicide safety planning-type interventions (SPTI) e.g. the Crisis Response Plan (Rudd, Joiner and Rajab 2001) or Suicide Planning Intervention (Stanley, Barbara and Brown 2012) can be effective for reducing the risk for suicide-related behaviours in a range of populations e.g. Hospital Emergency Departments (Stanley, B., et al. 2018); outpatients (Zonana, Simberlund and Christos 2018); US Army personnel (Bryan, et al. 2017) and; US Veterans (Reid, et al. 2015). A recent systematic review calculated that the risk of suicidal behaviour after engaging in SPTI was significantly reduced by 43% (Nuij, et al. 2021) although studies for self-harm have not found this effect (Gamarra, et al. 2015). At present, there have not been any published studies specifically exploring effectiveness for people in contact with the criminal justice system although an RCT for SPTI is planned for unsentenced persons in prison in USA (Johnson, et al. 2020). Further evaluation in prison leavers would provide important evidence for its utility in this population.

Evidence suggests when Safety Planning is used in clinical settings, a significant percentage (47%) of at-risk clients reported a greater sense of control over their mental health problems and an improved relationship with their mental health team because of crisis plans. The authors suggested that effective Safety Planning should focus on the collaborative development of structured plans which includes personal warning signs, self-management strategies, reasons for living, social supports, crisis supports and means restriction (Gamarra, et al. 2015) (Miller, et al. 2017)

Theoretical underpinnings

The integrated Motivational-Volitional (IMV) Model of Suicide (for full details read O'Connor and Kirtley 2018) is a tri-partite biopsychosocial framework of suicide, articulating the development of suicidality and behaviour. The presence of vulnerability factors and stressful life events creates a background which frames the next phase where suicidal thought and intentions can emerge, characterised by a sense of defeat and entrapment. There are many enablers or moderators which influence an individual's movement through this psychological pathway which include social problem-solving, belongingness, resilience, social support, goals and access to the means of suicide. Finally, further factors influence to move from ideation/intent to suicidal behaviour (O'Connor and Kirtley 2018). Key elements of this model have been supported within prison populations (Scowcroft, Winder, Oldfield & Slade 2020; Gooding, et al. 2017; Slade and Edelmann 2014; Slade, et al. 2014)

Collaborative Case Management

During the 2017/8 period there was a slight increase in the number of suicides within AP in E&W which were sustained through 2018/9 (MoJ, 2020a). Therefore, within all APs across England and Wales, a new approach to suicide and self-harm was implemented through 2020/21, based upon the best available research and practice evidence and reflective of the IMV theory.

The structural elements of this suicide and self-harm prevention approach consisted of two main elements which together provide a supportive structure from arrival and throughout the resident's stay, with the option of a step-up care package with escalating or critical risk of suicide or self-harm.

Box 1: Principles underpinning the dual-step approach include:

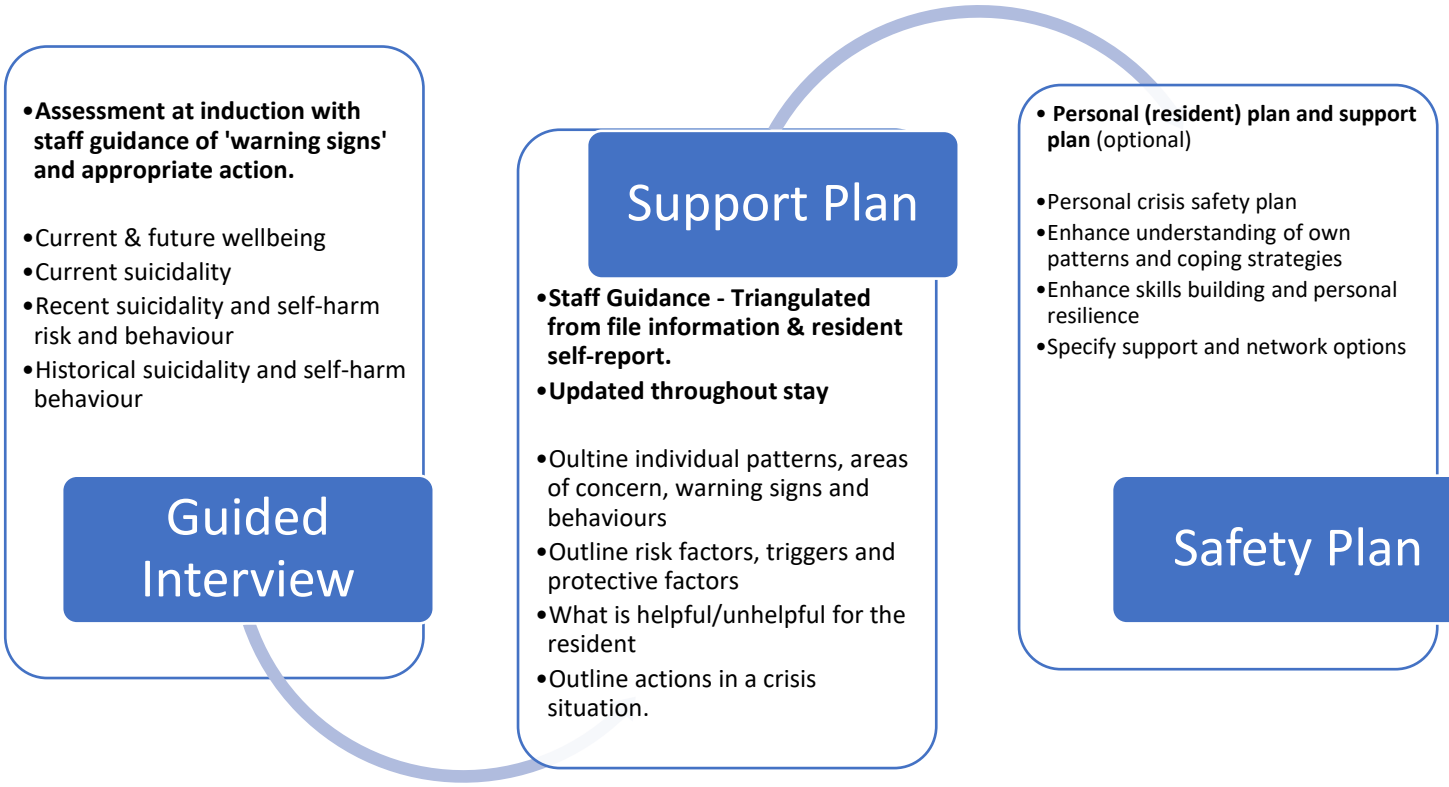
A focus on *prevention not prediction* of suicide
Embedding a greater person-centred, trauma- and theory-informed approach
Less emphasis on identifying risk factors and greater emphasis on supporting the person in-context.
Building structured supports to help guide both staff actions and residents' self-management.
A focus on collaborative and multi-disciplinary decision-making.
Supporting wellbeing and information flow through the complex transition from prison to community
Differentiating ongoing support from critical response.

The Support and Safety Plan (SaSP)

The Support and Safety Plan (known as SaSP) is the primary prevention approach and engages all residents throughout their stay in a 3-phase approach, irrespective of previous suicide or self-harm risk. SaSP provides an ongoing and dynamic collaborative approach to identifying and supporting the resident's areas of potential risk and their ongoing needs to support wellbeing and prevent distress. Completing SaSP in advance of any crisis also aims to play a vital role in keeping the resident safe during periods of distress or crisis by providing targeted and personalised support.

SaSP aims to provide individualised information and the opportunity to assess current areas of risk, triggers and needs for residents, how staff can help to prevent issues, and provide residents with a support structure including ways to support themselves in the event of distress. The SaSP approach also encourages the development of trust between residents to staff to talk about self-harm, suicide or distress whilst developing a collaborative and dynamic approach to wellbeing throughout their stay.

Figure 1: Outline of Support and Safety Plan (SaSP)



i) Guided Interview

The guided interview is a semi-structured conversation usually completed by each person's Keyworker, in the first hours or days of arrival. It has four sections linked to current and future wellbeing, current suicide and self-harm risk and recent and previous self-harm behaviour. There are indicative questions provided to assist staff which balances identification of risk with developing a trusting and 'caring' relationship with their keyworker. The 'guided' element of this interview extends to providing staff with guidance, based on research evidence and the IMV theoretical framework, on the indicators of current suicide and self-harm risk, with further guidance on any critical actions needed. This is not a comprehensive suicide assessment but provides a balance between screening for risk with identifying options for wellbeing enhancement and distress prevention; with the CARE approach initiated when a more detailed suicide or serious self-harm assessment is required.

ii) Support Plan

The Support Plan is a collaboratively developed and dynamic one-page guide for staff to understand the resident's risk of harm-to-self and provide personalised information on how best to work with them, identify issues and distress and provide personalised support. It is completed from a triangulation of prison and probation service file information and in discussion with the resident after arrival. It will be regularly reviewed and updated between the resident and their keyworker over their stay. To support the transitional phase from prison, the Support Plan is started before the person arrives, developed in liaison

with professionals (both in the community and in prison). After the guided interview, the Support Plan is co-developed between the resident and keyworker. It is grounded in a trauma-informed approach with the individual resident discussing helpful or unhelpful management approaches; and a collaborative agreement in advance of crisis regarding staff response to prevent unnecessary additional distress (e.g., the unexpected removal of items). The Support Plan can also support self-harm recovery, particularly for those in AP who may have longer term needs where crisis care is not currently required.

iii) Safety Plan

The Safety Plan is an enhanced SPTI and is presented as a stand-alone booklet designed for the person who is resident in the AP to understand and respond to their own suicidal ideation or risk of self-harm. A core element is a personal crisis safety plan, which anyone can develop to provide an individualised guide on ways to cope during a period of crisis or concern. There is focus on practical actions and is grounded in a strength-based approach to coping during a period of distress or crisis. The booklet has further sections which aim to support the person's understanding of themselves and enhance skills building and personal resilience. It also encourages the development of a support network.

Collaborative Assessment of Risk and Emotion (CARE)

The Collaborative Assessment of Risk and Emotion (CARE) is the second-stage case management approach, which is initiated when a current and rising risk of suicide or serious self-harm is identified. This, more targeted approach centres on safety measures, detailed psychosocial assessment and engaging a multi-disciplinary response e.g., the resident's community Probation Practitioner (PP or Probation Officer) and health services to provide the necessary actions to manage or reduce higher risk. CARE requires the engagement of the PP in decision-making at case review with all documents and notifications are placed onto nDelius (the Probation Service case management system) allowing access to both Probation and AP staff.

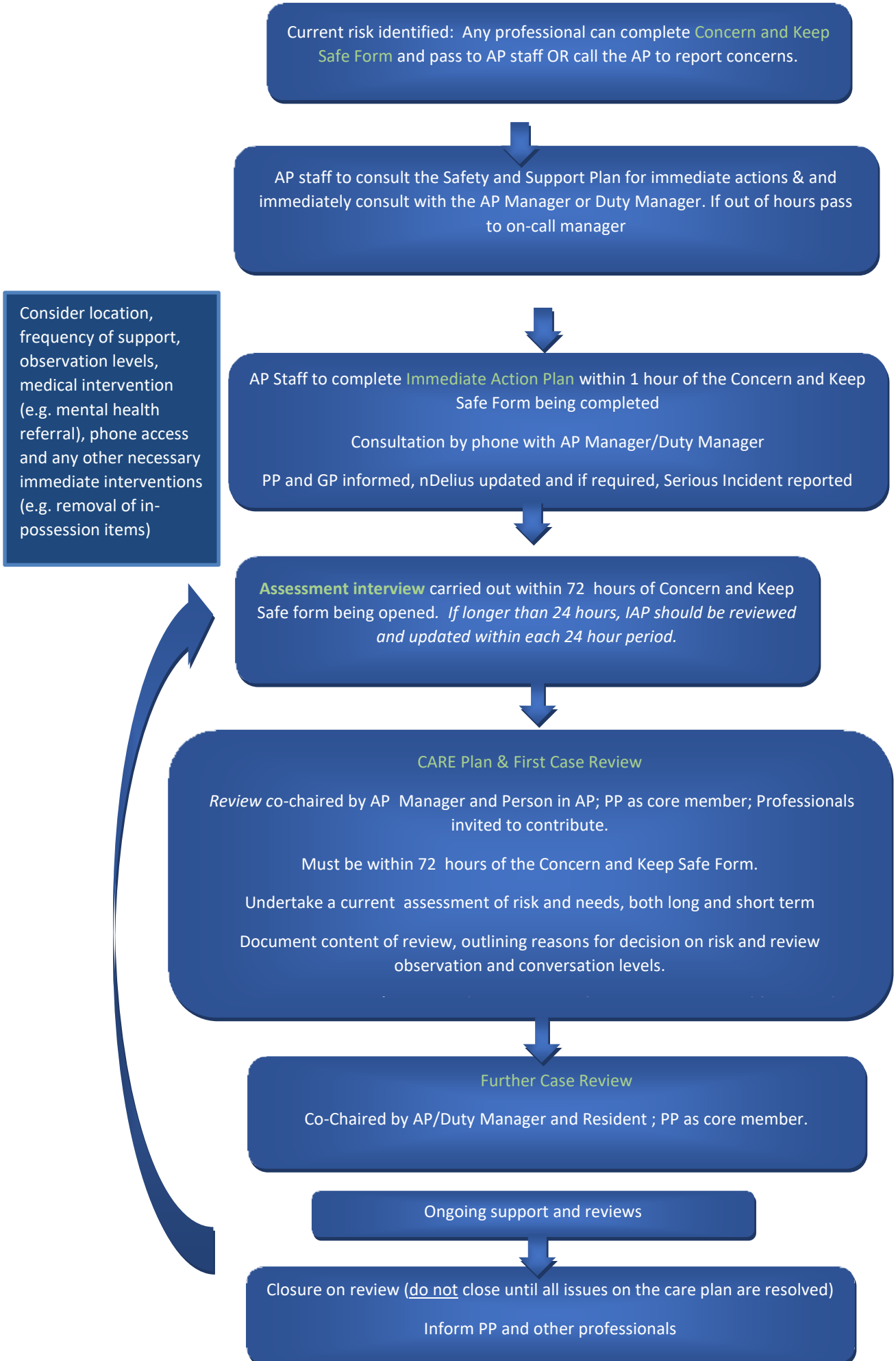
The CARE was named in collaboration with men and women under probation supervision to capture the essence and focus of the approach. CARE case management provides a framework which aims to assist staff to work together to provide support to people in AP who are at current risk of suicide or serious self-harm. Drawing from best practice in prison, inpatient and community settings, CARE emphasises person-centred, individualised and multi-disciplinary assessment, decision-making, and care planning (Slade and Forrester 2015). CARE has a series of recording stages, outlined in Figure 2.

Who is CARE for?

CARE should be initiated when an act of serious or unusual self-harm or attempted suicide has taken place, or any professional or member of staff judges that the individual is at current risk of suicide or serious self-

harm. To reflect the broader HMPPS position that suicide is everyone's concern, anyone working in, or for, the Probation Service can initiate a CARE. If a person arrives in the AP having been recently identified at risk in prison, it is advised that the CARE approach be initiated. Additionally, any member of staff or professional who observes behaviour, hears statements reflective of a current risk or receives information (including from family members or external agencies) which may indicate a risk, should consider CARE

Figure 2: Approved Premises CARE Process Flowchart



Box 2: CARE Structure

Concern and Keep Safe Form: Narrative form completed by the person with the concern, to outline their concerns, initial conversations with the resident and any early actions and, where external, is shared with the relevant AP immediately.

Immediate Action Plan: The *Immediate Action Plan* puts in place immediate support to keep the person at risk safe, until a full Assessment and Case Review can take place. It will be completed shortly after concerns raised and discussed with management. Considerations include imminence of risk, access to means, location, access to social support and mental health or substance needs.

Assessment Interview: The AP Manager or trained staff member will undertake a detailed assessment interview with the resident as soon as practicable. The assessment interview is grounded in a strong theoretical and evidence-base, designed to develop a clearer understanding of the current circumstances of the resident, the areas of risk and need and to inform the development of a CARE Plan at the Case Reviews.

Case review: The first review is an opportunity to collaboratively consider the initial Safety and Support Plan, discuss the current issues identified from the assessment interview and put in place a CARE Plan to address the urgent needs of the resident. The meaningful conversations and observations are reviewed at each case review. Each review should be co-chaired, where possible, by the AP manager and resident. The resident should be encouraged to be closely involved in decision making. Reviews should include more than one staff member and, as possible, to gain contributions from those involved in the care, e.g. AP Keyworker, PP, MH team or psychologist.

CARE Plan: The CARE Plan is the focal point of support for more imminent areas of risk or protective factors. The ambition is to prevent escalation of self-harm, a suicide attempt and reduce risk-related behaviour through a person-centred and collaborative approach with the resident. The CARE Plan is reviewed at each case review and its development should:

o Consider the known dynamic risks (including long-term risks) and identify actions to provide support, reduce risks and develop the individual's protective factors.

o Identify staff actions and self-management strategies and actions that the resident can employ, including access to services e.g. through A&E, interventions at periods of crisis and interim approaches whilst awaiting these services.

Ending the CARE approach: CARE can be closed once the Case Review considers all the issues and risks outlined on the CARE Plan are managed. The SaSP Support Plan should be reviewed and updated before CARE is closed. Daily meaningful conversations should continue for the 7 days following the ending of the CARE.

Post-closure interview: Within 7 days of the final CARE review, a manager will complete a post-closure interview with the resident to consider their current situation and whether additional support may be required. CARE can be re-opened if any concerns are identified.

CARE alignment with other systems of care

CARE aims to align with other systems of assessment and care. It works in tandem with the SaSP and provides a step-up when risk is raised or high and/or additional actions and multi-disciplinary working is required. The CARE case team will also review and update the SaSP as part of a 'step-down' from CARE. CARE aligns with the Assessment, Care in Custody and Teamwork (ACCT) case management system which operates in all prisons in E&W (Ministry of Justice 2020) as CARE operates the same basic structure as ACCT with its content and procedures adapted to fit to the AP and community context.

Meaningful Conversations and Observations

A common element within prison and inpatient policies is the observation or monitoring of a person at risk of suicide (NCCHC, 2019; WHO, 2007; US Department of Justice, 2007) although there is little evidence on its efficacy in prisons. Best practice recommends the engagement of the resident in meaningful conversations, with observations focussed on times when a conversation is not appropriate (e.g., at night or when with others). To reflect this, CARE emphasises meaningful conversation over a reliance on observations. In line with recommendations to minimise the negative impact of excessive intrusion (Pike and George 2019), CARE guides that the frequency of meaningful conversations and observations should be set at a level that reflects the assessed risk and needs with the engagement of the

resident. Furthermore, in line with trauma-informed practice, it is encouraged that staff discuss with residents the manner of both meaningful conversations and observations (e.g., in own room or private room; manner of approach).

T**raining and development**

Training and ongoing development is emphasised in effective suicide prevention within all international guidance. To support this, a broad training and development strategy is in place for AP staff & Managers and PP.

- All AP staff are required to attend the HMPPS' National Suicide Prevention Training (two-day training) which develops core understanding of suicide and self-harm behaviour; assessment and management; information sharing and self-care.
- All AP staff complete *Module 1: Safety and Support Planning* training in; with PPs encouraged to watch *Module 1b: SASP training for Offender Managers.*
- All AP staff, managers and PP are encouraged to complete *Module 2: Introduction to CARE training* and an instructional video: *Safety Plan Booklet* to understand the intersectional roles and processes.
- AP Managers should complete *Module 3: AP CARE Management* training.

Debrief, feedback and supervision

Supporting people at risk of suicide or who harm themselves is often difficult for staff and we should ensure staff have access to support and supervision, to help them to manage their own, human, reactions to difficult situations (Smith, et al. 2019). All staff are encouraged to engage in feedback and supervision regarding their use of SaSP & CARE. Regular group debriefs are recommended for AP staff to discuss current people at-risk to ensure staff are fully briefed and can openly discuss their own reactions and feelings. This aims to assist professional consistency, information sharing and staff wellbeing.

AP Managers or Area Managers will also undertake quality assurance on their use of CARE, providing supportive developmental feedback and where possible, reflective discussion with peers. This approach aims to develop of a sense of competence with peer supervision a valuable approach to providing support, especially with complex cases.

Post-incident support

Suicide and self-harm are often traumatic events and it is recommended that all staff should be provided time to express initial responses and some time away from front-line work or refined duties and not required to return to full duties immediately (Slade, Scowcroft and Dolan 2019). It is normal for staff to have an emotional response to events, and this will affect people differently and can surprise them. Managers and peers are encouraged to provide normalisation of this response so that staff feel able to express honestly and to seek further assistance, if required. Within HMPPS, all staff can access a range of support including a Structured Professional Support service to reduce the likelihood of adverse effects of supporting people at risk of harm (HMPPS 2020)

Next steps

In late 2021, an internal HMPPS Implementation Assurance Audit (IAA) for the SaSP and CARE was completed and this confirmed that these approaches were in place within AP across E&W. There was consistent use of the SaSP Guided Assessments and Support Plans for the majority of residents within the first days of arrival; with the CARE approach initiated for those at greater current risk (e.g. a serious episode of self-harm, signs of significant distress or current mental health concerns).

Collaborative working with external services is emphasised in the development and management of CARE. However, there is no requirement for non-justice professionals to engage with our approaches. The IAA on CARE indicated that although the GP or healthcare professional would be informed of current risk, there was limited evidence that this resulted in meaningful health engagement in CARE or in cross-service risk management. Increased effective partnerships working between justice and health services to manage suicide risk in prison leavers continues to be an area for development.

Further evaluation is required to consider the effectiveness and inform these developments, although the ongoing Prison and Probation Ombudsman's investigations into deaths within AP will provide scrutiny and learning regarding the use of these approaches for those who tragically die during their residency.

This case management approach is only fully available for prison leavers within APs, a population who are deemed high-risk of offending. Research and official data on suicides in those under probation supervision suggested that low and medium risk people under

supervision (Ministry of Justice 2020) are at greater risk of suicide. To provide wider support to all prison leavers and people under supervision, the Safety Plan is also accessible beyond those in APs, to all men and women under probation supervision who may be at-risk, through their PP.

Conclusion

Prison leavers and those under probation supervision are at significant risk of suicide and self-harm yet there is limited academic evidence, official guidance or specialist approaches available to meet this need. By drawing on 'best practice' from international correctional and community services coupled with evidence from probation-specific research, this new two-stage approach for people in AP endeavours to bridge the gap. The multi-facetted, structured but individualised SaSP and CARE approaches have been successfully rolled out across the AP estate in England & Wales. They are being embedded as business-as-usual practice for AP with elements being made available across probation to support all people under supervision.

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